

Childless Adult Coverage in Maine

State Report

by

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INTRODUCTION

In February 2002, Maine submitted a waiver to the Centers for Medicare and Medicaid Services (CMS) to expand MaineCare (Medicaid) to childless adults with income at or below 125 percent of the Federal Poverty Level (FPL).¹ CMS approved the waiver on September 13, 2002, and less than three weeks later, the state began enrolling childless adults into “MaineCare,” a program name that encompasses Medicaid (including the non-categorical adult expansion) and SCHIP. Childless adults had not been eligible for public coverage since a capped, state-funded program offering Medicaid-like coverage ended in 1995 due to lack of resources.

The lack of available health insurance for childless adults was reflected in higher-than-expected early enrollment numbers for what the state calls its “non-categorical expansion.” As of October 2003, the state had enrolled 16,854 adults in the expansion program, and approximately 13,000 of these adults were receiving services through managed care.²

It is not unusual for an expansion program targeting the low-income uninsured to receive a significant amount of attention from potential eligibles. What is unusual is that, at a time when most states are cutting back on benefits and eligibility for publicly funded programs, Maine decided to both expand their MaineCare program and to provide the new population with the full MaineCare benefit package. Like almost all other states, Maine is experiencing budget deficits due to the combination of lower tax revenues and higher spending on social programs. However, unlike most other states, it had not been using a significant portion of its federally allocated Disproportionate Share Hospital (DSH) funds. Sensing an opportunity to support the acute care hospitals and other providers that were supplying a good deal of uncompensated care for childless adults, the state proposed that a waiver be granted that would allow them to include unspent DSH funds as part of their federal matching dollars that could be used to expand Medicaid coverage for this population.

But many Maine policymakers and stakeholders were not satisfied with just expanding MaineCare coverage to childless adults. In a move that is even more unusual given the economic situation across the nation, the State legislature voted in favor of, and the Governor signed, a large-scale health care reform proposal, the goal of which is to ultimately provide universal coverage for its citizens. The Dirigo Health Insurance plan, unveiled by Governor Baldacci in early May 2003, includes a number of initiatives that would provide access to health coverage for up to 180,000 uninsured, such as providing subsidies for purchasing health coverage for individuals with income below 300 percent of the FPL, increasing MaineCare eligibility for childless adults up to the full 125 percent FPL level approved by the waiver, and for parents up to 200 percent of FPL. The plan would elicit savings by pooling individuals and small groups together and would be funded by combining dollars from employers, individuals, the State, and the federal government, and by redirecting funds now being spent on bad debt and charity care. The Governor does not propose directing new appropriations toward the plan, but rather sees its funding coming from savings in uncompensated care, quality initiatives and perhaps most importantly, cost-effective pooling strategies.

¹ The state set eligibility at 100 percent of FPL, with the option of raising it to 125 percent of FPL if funds were available. The Federal Poverty Level was \$15,260 for a family of three in 2003.

² Approximately 3000 enrollees were exempt from enrollment in the primary care case management system, and receive care through a fee-for-service mechanism.

This paper provides an overview of Maine’s efforts to cover low-income childless adults. It is based on interviews with key stakeholders and document reviews, which took place as part of a larger multi-state examination of coverage available to low-income childless adults.

OVERVIEW OF WAIVER COVERAGE

Currently, the state has implemented its expansion in childless adult coverage up to 100 percent of the FPL, although, under the waiver, it has authority to expand eligibility up to 125 percent of the FPL. Childless adults have the same benefit package, cost sharing requirements, and enrollment process as non-expansion MaineCare parents. The only difference is in the income threshold for eligibility. Parents with children under age 19 living at home are eligible at or below 150 percent of the FPL.³ Other details of MaineCare for childless adults are described in Table 1 below:

Table 1. MaineCare Program For Childless Adults

Enrollment	16,854 as of October, 2003
Eligibility	100 percent of the Federal Poverty Limit (monthly income of \$749 or less if single, or \$1,010 or less if married and living with spouse)
Asset Limit	\$2000 per individual; \$3000 per couple. Not all assets are counted.
Benefits	Full MaineCare benefit package, including inpatient and outpatient hospital care, physician care, ambulance and non-emergency transportation, lab and x-ray, home health, dental, prescriptions, and vision.
Cost-Sharing	No monthly premium. Nominal copayments for services.

Eligibility

Eligibility is based on income level and assets⁴. At this time, childless adults whose income is at or below 100 percent of FPL can be deemed eligible for MaineCare, but if appropriations are available, the waiver allows the state to raise income eligibility to 125 percent of FPL after the first year. The Dirigo Health Insurance plan (mentioned above and described later in this report) does incorporate the waiver authorization by raising the income eligibility for childless adults to 125 percent as one of its mechanisms for improving coverage rates.

Benefits

Childless adults receive the same comprehensive benefits as other Medicaid enrollees, including the following: inpatient and outpatient hospital care, emergency room care, physician services, lab and x-ray services, ambulance and non-emergency transportation, home health,

³ In addition, Maine has a transitional program for parents which allows them to remain covered for an additional year if their income goes above 150 percent of FPL, as long as it remains below 185 percent FPL. Those in the transitional program do pay a small premium, however.

⁴ Enrollees must have assets below \$2000 for an individual or \$3000 for a couple; savings of less than \$8000 for an individual and \$12,000 for a couple. Home, car, savings for college, and other assets, are not counted against eligibility.

long-term care, prescription drugs, mental health and substance abuse treatment, durable medical equipment, dental, vision, hearing, and occupational, physical and speech and language therapies.

It was anticipated that providing the same comprehensive benefit package to all childless adults as are provided to other MaineCare beneficiaries would make the program easier to administer for both MaineCare staff and providers. Stakeholders commented, however, that only certain dental services are covered, and it is becoming increasingly difficult to access oral health providers anywhere in the state. In addition to dental services, some safety net providers spoke of the difficulty in accessing other specialty care services for their patients, such as dermatology and orthopedics.

Cost Sharing

While childless adults are not assessed any premium payment for their participation in MaineCare, there is nominal cost-sharing for some services⁵ in the form of copayments. For those services that do require copayments, enrollees are charged a sliding scale fee between one and three dollars, with a cap on how much an enrollee can spend out-of-pocket on a particular service in one month. As of July 1, 2003, however, a different cost-sharing schedule was implemented for pharmaceuticals, with copayments ranging from \$.50 to \$3.00 per prescription, with a newly implemented out-of-pocket cap of \$25 per month.

Enrollment Process

Childless adults use the same application form as other MaineCare applicants. The form is mailed or delivered in person to the local Department of Human Services office, and must include proof of income for the past four weeks. A decision on eligibility is usually given within two to three weeks, and must be made within 45 days from receipt of application. The state allows up to three months of retroactive payment for services provided. While enrollees must recertify every twelve months, this does not mean they have twelve months of continuous enrollment. If an enrollee reports an increase in income or assets above the MaineCare eligibility level, they may lose coverage during that twelve-month period.

Service Delivery System

While there is a fee-for-service option available in MaineCare, the majority of MaineCare enrollees (not including elderly and disabled) are enrolled in a primary care case management (PCCM) system. Unlike many other states, 93 percent of the state's primary care providers participate in MaineCare PCCM. In this model, primary care doctors are paid a small management fee per MaineCare enrollee, as well as fees for services rendered. For providers who participate in MaineCare PCCM, the state has instituted a Primary Care Physician Incentive Payment, designed to provide additional compensation to physicians who rank above the 20th percentile for certain measures. The measures are related to access (e.g., size of MaineCare patient caseload), utilization (e.g., emergency room use), and prevention/quality (e.g., screening rates). State officials commented that the expansion included a roll-out period lasting from January 2003 to September 2003 for enrolling childless adults in the PCCM, and that the state worked closely with providers who were technically closed to new patients to open

⁵ Examples include in- and out-patient hospital care, lab, x-ray, mental health and substance abuse care, home health, and ambulance service.

up additional slots to enrollees. Many providers opened up their practices voluntarily to take on new MaineCare patients.

There are several circumstances under which a member would receive care through a fee-for-service mechanism rather than the PCCM. As of July 2003, 13 percent of the childless adult enrollees are getting care on a fee-for-service basis due to health status, geographic location, or other PCCM exemption categories.⁶ In addition, those who already have insurance with comprehensive coverage but are income-eligible for MaineCare can receive wrap-around benefits on a fee-for-service basis outside of the PCCM managed care product.

FINDINGS

Waiver Development

The MaineCare expansion to childless adults was authorized by L.D. 1303, “An Act to Increase Access to Health Care,” which was passed in September 2001, before being proposed to CMS as a Section 1115 waiver. This piece of legislation, however, started out as a much broader package of reforms that were to have built upon Medicaid through eligibility expansions and broader asset and income disregards, as a way to begin moving toward universal coverage. In 2000 Speaker of the House of Representatives Michael Saxl introduced two health care reform bills. The first, referred to as the public health bill, would have increased the income eligibility level for childless adults to 250 percent of FPL and for parents up to 300 percent of FPL, and expand pharmaceutical benefits, which would be funded with a \$.50 increase in the tobacco tax. When then-Governor Angus King opposed that source of funding, the bill was changed to use revenue collected through a tax on businesses that carried forward operating losses in order to offset profit gains in future years.⁷

Before being finalized, there were a number of changes made to the bill including changing the name of Medicaid and Cub Care (SCHIP) to “MaineCare,” and setting the income eligibility level for childless adults to 100 percent of FPL (with the option of going to 125 percent of FPL). Income eligibility for parents remained at its original level of 150 percent of the FPL. Approximately \$1 million in state funding was added to shore up operating costs for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Finally, the tax on businesses was dropped, and the cigarette tax was reinstated, albeit at a \$.06 increase rather than the original \$.50 increase.

There was no uproar among hospitals or other institutions when the state tapped DSH money to make up the federal share of its waiver. Previously, a portion the DSH allocation had been divided up among psychiatric hospitals and community hospitals, neither of which traditionally met their DSH limit. On the contrary, rather than opposing the transfer of these moneys to the coverage expansion, the hospital community had argued for years that providing coverage to the low-income childless adult population would be cost effective in the long run. In a report entitled “Closing the Gap: Ten Steps to Reduce the Number of Maine People Without Health Insurance,” (December 2001) the Maine Hospital Association argued in favor of increasing the income eligibility levels in state insurance programs. A driving factor behind this argument was

⁶ Exemptions are available for the homeless, those with language barriers or cultural needs that cannot be met by MaineCare providers, those with health care needs are best met by a provider who does not participate in the program, and migrant farmworkers

⁷ This business practice is defined as “net operating loss carryback.” The tax on the practice was proposed to both fund the public health bill, and to close a tax loophole in the state’s tax code.

a reported significant increase in emergency room utilization for non-emergent care among uninsured adults without children.

A broad coalition of stakeholders worked with Speaker Saxl first to develop the original public health bill, and then to design the childless adult expansion, which would become the most significant component to survive the bill's debate. The Speaker put together a "kitchen cabinet" that included Maine health care experts Trish Riley, Ellen Schneider, Charlene Rydell, and Brian Atchinson. Working with the cabinet was a broad coalition of partners who provided significant input in drafting the public health bill and later, implementing the MaineCare expansion. The coalition included advocates such as the Maine Equal Justice Project, Consumers for Affordable Health Care, and the Coalition for a Tobacco-Free Maine; provider associations, such as the Maine Medical Association and the Maine Hospital Association; service delivery/safety net organizations such as the Maine Primary Care Association; mental health agencies and organizations, the MaineCare program staff at the Department of Human Services, commercial insurers, and other legislators, both past and present.

It was this group that proposed the idea of shifting DSH funds to the creation of a coverage expansion. The consensus was that any new health insurance coverage should not only be implemented incrementally but that it should be administered and funded through a MaineCare expansion that taps a federal match. The state's prior experience with the Maine Health Program, a state-only funded program for the uninsured, ended in 1995 due to lack of money, a situation that the state did not want to repeat. That program, which lasted for six years, covered all adults up to 100 percent of FPL and children up to 125 percent of FPL. It offered benefits similar to MaineCare, and required nominal cost sharing in the form of premiums and co-payments. Enrollment in the program reached a peak of 4,000 in 1993, at which point it was capped. When the program was terminated two years later, children who were enrolled in it were transferred to MaineCare, and adults lost coverage completely. A former legislator who had helped to develop the Maine Health Program was brought into the coalition to advise the group on what is and is not reasonable to achieve with state-only dollars.

Across the board, informants reported that using the Medicaid waiver process to expand coverage to childless adults was the best option available. In addition to allowing the state to leverage federal resources, it would make for an easy transition administratively for enrollees, providers, pharmacists, and advocates for the uninsured. Some stakeholders were concerned that the stigma associated with Medicaid--which was one of the factors behind the state's decision to change the program's name to MaineCare--would be a problem. However, other stakeholders thought that most citizens knew someone on Medicaid and were familiar and comfortable with the program, so that stigma would not be an issue. In any case, the factors in favor of providing childless adult coverage through a Medicaid expansion far outweighed those opposed.

One factor that figured very prominently in building support for the expansion was the high number of working uninsured. Approximately seven out of ten Maine's uninsured residents are employed, mirroring the national figures.⁸ Democrats were supportive of the bill on the merits of covering more uninsured (although there were members of the Democratic caucus who argued that the cigarette tax being used to fund the expansion would be regressive and hurt low-income populations). More conservative Republicans were won over by the fact that so many working individuals, many of whom are employed by or run small businesses that make up the majority

⁸ "Closing the Gap: Ten Steps to Reduce the Number of Maine People Without Health Insurance," Maine Hospital Association, December 2001.

of Maine's industry, don't have access to coverage. There is virtually no commercial individual insurance market in the state, so those who cannot afford coverage in the group market and do not qualify for MaineCare are left to pay out-of-pocket or receive charity care at clinics, CHCs, hospitals or other safety net institutions.

Maine's providers have traditionally expressed their support for incremental expansions in MaineCare in general, and were very supportive of the childless adult expansion in particular. But, groups representing both physicians and hospitals noted that they did not want the expansion to result in lower provider reimbursement rates. In the case of the childless adult expansion, physician rates remained the same, but hospital rates were lowered, leading both groups to worry about what the future might hold as the state continues to seek ways to increase coverage.

One facet of the original public health bill upon which almost everyone agreed (kitchen cabinet members, coalition partners, and legislators alike) was that health coverage should be based on income level, rather than on family status. Most stakeholders shared the philosophy that the high cost of caring for the uninsured gets paid by the community in the long run, either in the form of higher costs of commercial coverage, hospital service shortages, crime, etc. In addition, there was the argument that parents should not have to lose coverage when their children were no longer considered dependents. Finally, there was the recognition that a significant number of uninsured fell into this category of adults without dependent children living in the home, and that, by covering them, the state could begin to make a meaningful dent in the uninsured population.

Despite the high level of consensus within the legislature for expanding coverage, the original bill still suffered some casualties. The final version cut the tobacco tax from \$.26 to \$.06, lowered the income eligibility for childless adults to 125 percent of FPL⁹, and failed to raise the income eligibility level for parents. However, the bill made the asset tests more favorable for enrollees, and instituted a 12 month recertification cycle. Finally, it consolidated all the Medicaid/SCHIP coverage under the name *MaineCare*.

Despite the decreased scope of coverage expansion in the final bill, it was threatened with a veto by the office of out-going Governor Angus King. Negotiations between the Governor's office and the coalition members led to its eventual passage. However, when Governor Baldacci took office in January 2003, he proposed a number of MaineCare-related cuts, including closing enrollment in the expansion in order to close a \$1 billion budget gap. Because the legislature produces a biennial budget¹⁰, this would have frozen the expansion for two years, essentially killing it according to some informants. Once again, supporters in the legislature, at DHS, and other members of the original coalition worked closely with the Governor's office to save the funding stream and guarantee the expansion's operation until 2005.

Although there were some traumatic moments concerning the fate of the childless adult expansion as the new Governor dealt with the state's budget situation, Baldacci has made health care a major priority on his agenda. This is reflected not only by his decision to keep the childless adult expansion operating, but also by the announcement in May 2003 of a proposal

⁹ MaineCare is approved by CMS to enroll childless adults up to 125 percent of FPL, but the bill as it is currently funded only goes up to 100 percent of FPL.

¹⁰ Although the Maine legislature does meet annually, it conducts a shorter session during alternate years.

called the Dirigo Health Insurance (DHI) plan, the ultimate goal of which would be to institute universal health coverage in the state of Maine.

Waiver Negotiations

The stakeholders interviewed for this report agreed that waiver negotiations with CMS went smoothly. While the proposal did raise the profile of unspent DSH to the level of federal policymakers, who questioned the wisdom of shifting it to other uses, these questions were resolved fairly quickly and easily. The review of Maine's waiver proposal began shortly after the Bush administration's call for proposals under the new Health Insurance Flexibility and Accountability (HIFA) initiative, which encouraged states to expand coverage using existing resources. With that directive in place, the state's argument for using unspent DSH funds was easier to make, and was ultimately successful. In fact, the negotiations around using DSH money were more strained within the state prior to the proposal being sent to CMS than they were between the state and the federal government. All in all, the straightforward approval of the waiver was attributed to the fact that it was an uncomplicated proposal. There was some speculation that approval was also made easier by the fact that the proposal was submitted soon after the release of the HIFA initiative, when CMS may have been especially motivated to approve waivers under the initiative.

Childless Adult Enrollment

In the waiver proposal, the state estimated that 11,000 new members would enroll in the first year, but actual enrollment has far exceeded expectations. As of October 2003 – about fourteen months after implementation – 16,854 newly eligible childless adults had enrolled in MaineCare. While some of this may be due to pent-up demand, several informants cited the excellent outreach work done by the Department of Human Services as the major reason for the immediate interest in the program. Once the waiver was approved, the Department reviewed its program databases, such as the one on Food Stamp enrollment, to automatically enroll those who were found to be eligible based on available information. The Department also worked with the Department of Behavioral and Developmental Services and the Department of Education to send information on the availability of new coverage to individuals enrolled in their programs. This resulted in approximately 5,000 individuals enrolling "overnight," according to state officials.

Many stakeholders interviewed expressed surprise at the high number of enrollees that entered the expansion so early in its implementation. While there was recognition that the uninsured childless adult population used a large number of safety net services, it was expected that initial enrollment would take place gradually. The rapid enrollment was viewed primarily in a positive light. Much praise was given to the Department of Human Services for being proactive in its outreach to individuals who were already receiving benefits from other state-run programs and, therefore, likely to be eligible for the expansion.

Analysis of the current enrollment reflects that the demographics of the MaineCare expansion population were somewhat different than expected. The anticipation was that a significant majority of enrollees would be young men in their early twenties, but the average and median age was slightly more than 39 years old, and nearly 45 percent of enrollees were female.

Cost and Utilization

During the first six months of operation, pharmaceutical spending has been higher than expected. According to the Department of Human Services, the state spent approximately \$3.9 million on drugs for 9,428 members as of April 2003. Trending forward to the next fiscal year, the state is looking at a price tag of \$13 million for pharmaceuticals alone, assuming no increase in enrollment, which is highly unlikely. Data indicates that approximately one-third of prescriptions filled were for psychiatric drugs, 14 percent were for pain medications, and 10 percent were for Gastro-Intestinal medications. Also included in this sample are 15 to 20 HIV and Hepatitis C patients, who require very expensive pharmaceuticals. The state based its original estimates of the cost of providing pharmaceutical benefits to the expansion group on costs for non-disabled MaineCare adults, which is approximately \$470 per year. However, the childless adult costs are almost three times higher at \$1300 per year. At this point, the state has not considered making any changes to the pharmaceutical benefit or to eligibility standards, but will continue to carefully track expenditures in this area.

Utilization of non-pharmaceutical services has been in line with predicted levels, with the highest utilization coming in the area of mental health services and chemical dependency treatment. Expansion enrollees utilized a wide variety of services, with inpatient, outpatient, physician, private non-medical institutions, community support services, and substance abuse treatment being at the top of the list in terms of number of encounters and dollars spent by the state. As part of the negotiations that ensured the expansion's continuation in the next budget year, the state cut funding to its mental health agency by \$1.9 million. The coalition argued that since the expansion would lead to more individuals accessing mental health services that could be reimbursed by MaineCare, the mental health agency would not suffer from the loss of funds. There is anecdotal evidence that the MaineCare expansion has led to cost offsets in public spending for mental health services, as well as for substance abuse treatment.

After approximately eight months of operation, anecdotal reports by hospital industry spokespersons suggest that the childless adult expansion has increased hospitals' costs of caring for this population, due to the increase in utilization of outpatient and specialty services among MaineCare members who can now visit primary care providers and obtain referrals for specialists. But, while hospitals are currently providing more services for this population, they are now being reimbursed for the care at a much higher rate than when services were written off as charity care, and more importantly, this formerly uninsured population is receiving needed care that had been neglected or could prevent more serious conditions in the future. Concerns remain, however, regarding how hospitals in largely rural areas -- where the hospital is the main provider of not only inpatient and outpatient services, but also primary and specialty care -- will be able to cover the increased costs associated with the expansion.

Dirigo Health Insurance Plan

After the waiver expansion was implemented, the state moved forward with further health care reform and expansion through the Dirigo Health Insurance Plan (DHI). The DHI focuses on a sector that makes up a large percentage of the uninsured population in Maine and across the country: small business owners and employees and the self-employed. Its initiatives build directly upon Maine's Small Business Health Coverage Plan (SMBHC). The SMBHC was passed in the 2001 legislative session, and had not yet been implemented when DHI was first

proposed. The two plans are nearly identical, but for two main differences: the SMBHC would only apply to small businesses with either 50 or less employees, and it did not include pooling mechanisms designed to control costs.

Dirigo Health’s program for small businesses and the self-employed would create a subsidized health insurance plan governed by an 11-member board. The legislation, which was passed in 2003, states that the plan must be available by January 1, 2004. It is unclear, however, how the DHI will affect the implementation of the small business health plan. Table 2 describes the various initiatives that will take place under the DHI umbrella, categorized by major policy goal and/or operating mechanism, and Table 3 outlines strategies by which these initiatives will be financed.

Table 2: Dirigo Health Insurance Plan Initiatives

<p>Coverage and Access</p>	<ul style="list-style-type: none"> • Create a subsidized health insurance product, to be delivered by private carriers, offering comprehensive coverage to workers in small businesses who work 20 hours a week or more, self-employed individuals, and individuals without access to employer coverage, as well as their dependents. Employers would pay up to 60% of the cost, and employees would pay the remainder, with the help of state subsidies for those under 300 percent of FPL. • Increase MaineCare income eligibility for parents up to 200 percent of FPL and for childless adults up to 125 percent of FPL. Add a premium subsidy option for MaineCare enrollees who have access to employer sponsored coverage, with a MaineCare wraparound. • A second phase of the initiative would open up the subsidized Dirigo Health plan to large employers at a future date.
<p>Cost Containment</p>	<ul style="list-style-type: none"> • Implement one-year voluntary caps on cost and operating margin of insurers, hospitals and providers. • Create a <i>Capital Investment Fund</i> to place capital expenditures on a global budget for resource allocation. • Regulate premium increases by requiring small group health plans to submit rate filings to the Superintendent of Insurance for review and approval.
<p>Quality Improvement</p>	<ul style="list-style-type: none"> • Establish the Maine Quality Forum (MQF) to collect and disseminate research, adopt quality and performance measures, issue quality reports, promote evidence based medicine and best practices, encourage adoption of electronic technology, and make recommendations to the State Health Plan.

Table 3: Mechanisms for Financing Dirigo Health Plan Initiatives

- Funnel resources collected through cost-sharing by DHI-participating individuals and businesses back into the program.
- Use a combination of DHI resources (e.g. cost-sharing) and federal funds for expanded MaineCare eligibility.
- Capture realized savings from the reduction in bad debt and charity care through savings offset payments by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers. Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings.
- Use the savings offset payments to fund subsidies for those with incomes above MaineCare eligibility and below 300% of the FPL after the first year and to fund the Maine Quality Forum.
- Use about \$52 million one time monies to fund subsidies during the first year of Dirigo Health enrollment and about \$1 million to launch the Maine Quality Forum, until savings offset payments materialize.

Both the Maine Senate and House approved the proposal, which is being called the nation's first universal health plan¹¹ and the state hopes to begin operating the program in July 2004. Maine expects to enroll approximately 31,000 people in the first year, and 180,000 individuals by 2009. The MaineCare expansion component alone would make an additional 7,000 people eligible for the plan annually.

DISCUSSION

Maine exhibited certain unique features – such as a relatively homogenous population and the availability of unused DSH funds – which contributed to the successful passage of the MaineCare childless adult expansion. But the story of how, during a period of economic downturn, Maine was able to not only expand coverage to childless adults but also pass sweeping health coverage legislation, may hinge primarily on the extremely strong relationships among the state's primary stakeholders. In addition to its traditional commitment to help the underserved, it was the combination of Maine's demographics and its small geographic dimensions that allowed for the development of a committed coalition of stakeholders, with representatives from almost all major provider, policymaker, and consumer groups. Subsequently, these stakeholders were able to put aside their individual needs and focus on what would best serve the needs of the community.

While any or all of these circumstances may not exist in other states, key informants offered advice to other states interested in expanding coverage, either in general or to childless adults in particular. First and foremost was to use Medicaid as a way to leverage federal funds. Given the state's experience with a state-only funded program in the late 80's/early 90's, it is not

¹¹ Kaisernetwork Daily Health Policy Report, 6/16, "Maine Legislature Approves Universal Health Plan."

surprising that they advocate expanding coverage by expanding MaineCare. In fact, several informants spoke of the potential benefits of “Medicaid-izing” other services, such as pharmaceuticals and other specialty care services, for other uninsured populations.

Second, informants stressed the importance of not treating the childless adult population as an entirely separate category. Granted, the Medicaid waiver proposal did pertain specifically to childless adults, but in practice it blends that population in with the rest of the MaineCare enrollment pool by equalizing the benefit package and other aspects of the program across members. The decision to provide childless adults with a comprehensive benefit, thereby creating one program for all members, is a feature of expansion that stakeholders were proud of, and would suggest to other states. This is not only for administrative ease (although that is a big factor, both for providers, program staff, and policymakers), but also because of the message it sends that newly eligible citizens are no less “deserving” or less in need than others.

Third, informants stressed that it is more cost-effective for the state to pay for coverage than for society to pay the myriad costs – not all health care related – that result from having a significant portion of the population uninsured.

Finally, the state’s leaders, from the Governor on down to the legislature and other stakeholders, firmly believe in the link between the health of the economy, health care spending, and individuals’ ability to obtain affordable health care. They realize that without a functioning health care system, workers’ productivity may decrease. But even more importantly, every dollar that the state inefficiently spends on ever-growing health care costs is one less dollar to invest in the economy and the development of new and existing industries.

Stakeholders had several suggestions for changes that could be made at the federal level that would ease the way for states to expand coverage to childless adults and other populations that have traditionally been restricted from federal program eligibility. Aside from increasing the federal percentage of FMAP funds, informants suggested creating a mechanism that would allow states to include estimated cost offsets from other programs (Medicare in particular) from expanding Medicaid coverage when calculating budget neutrality, or perhaps eliminating the budget neutrality requirement altogether. Another suggestion, one with which Maine has experience, is to allow multiple states within a given region work together to create larger pooling possibilities and elicit greater cost-savings from state programs that serve low-income individuals.¹²

CONCLUSION

On its surface, Maine’s experience may be considered unique, given that they chose to expand coverage to childless adults at a time when the fiscal environment would suggest reducing public spending. Granted, the state was in a position of having a pool of federal money that they could apply to their Medicaid match, thereby making the demonstration of budget neutrality less of a burden than it would be for other states. But, at the same time, it was facing the same budgetary deficits that might have stopped other states from considering raising or diverting revenue to come up with the state’s share of the expansion. Therefore, it may be more useful to look at the childless adult expansion as a byproduct of what is truly special about Maine’s

¹² This refers to Maine’s attempts, in conjunction with Vermont and New Hampshire, to set up a purchasing pool and prescription benefit management organization in order to reduce the cost of buying pharmaceuticals for state beneficiaries.

accomplishment: the ability of its stakeholders to respond to its citizens' needs in a timely and creative way.

The technical aspects of coalition building are generalizable and could be transferred to other states. But Maine's size, its labor market demographics, and its population demographics in general contributed to the childless adult expansion receiving so much support. While these may not be applicable to other states, the lessons learned in Maine – in particular, those regarding the effects of uninsurance on employers and the market – can be seen as a sign of things to come for other states whose population size and market diversity may have thus far perhaps shielded them from more significant budgetary pain. It will be fascinating to watch now as this state continues on its journey to universal coverage with the new Dirigo Health Plan and the Small Business Coverage Plan.

SOURCES

Interviews with the following:

- Peter Walsh, Acting Commissioner of Human Services
- Christine Zukas-Lessard, Jude Walsh, Marianne Ringel, and Brenda McCormick, MaineCare
- Michael Saxl, former Speaker of the Maine House of Representatives
- Mary Henderson, Maine Equal Justice Project
- William Browne and Lynne Gardner, Office of the Speaker of the Maine House of Representatives
- Kevin Lewis and Martin Sabol, Maine Primary Care Association
- Andrew MacLean, Maine Medical Association
- Charlene Rydell, Office of Congressman Thomas Allen, former state representative/Chair of Insurance Committee
- Mary Mayhew, Maine Hospital Association

“Closing the Gap: Ten Steps to Reduce the Number of Maine People Without Health Insurance,” Maine Hospital Association, December 2001.

“Section 1115 Waivers at a Glance: Summary of Recent Medicaid and SCHIP Waiver Activity,” Kaiser Commission on Medicaid and the Uninsured, April 2003.